RESET

STATE OF TENNESSEE
OPTIONAL GROUP SPECIAL ACCIDENT PROGRAM ENROLLMENT CARD

Please Print

Full Name of Employee	Social Security Number	Agency Code	Hire Date

Single ☐ Married ☐	Male ☐ Female ☐	Birthdate MM/DD/YY	Name of Beneficiary	Social Security Number	Relationship

If you wish to insure your eligible dependents, please provide the information requested below. See definitions at right.

Social Security Number	Name Last, First, Mi	Birthdate MM/DD/YY	Relationship Code	Sex	Acquire Date	Student
						❑Y ❑N
						❑Y ❑N
						❑Y ❑N
						❑Y ❑N
						❑Y ❑N

Relationship Codes	Acquire Date
SP-legally married spouse	Date of marriage
CN-natural or adopted child	Date of birth or placement in home
CS-stepchild for whom you or your spouse has legal or joint custody	Date custody obtained
CL-any child for whom you are the legal guardian	Date appointed guardian
CT-any child for whom you provide support and claim as a dependent on income tax	Date you were able to claim child on federal income tax

Attach a separate sheet if more space is needed.

FA-0831 Rev. 12/98

Sign on backside and return to your agency's insurance preparer.

EMPLOYEE CHANGES

Change name from _____ to _____

Change beneficiary to _____ Relationship _____

Change type of coverage from _____ to _____
Single or Family

☐ I wish to terminate coverage on myself.

☐ I wish to terminate coverage on my dependent(s).
(List social security number(s) and name(s) in the space provided on the front of this card.)

Effective date of changes

Signature

Date

Return this card to your agency's insurance preparer.

I hereby authorize my employer to deduct from my salary (or wages) the required contribution for the Optional Speical Accident Insurance for which I am, or may become, eligible under the group policy available to me as an employee of the State of Tennessee.

Signature Date